Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

June 14, 2022

Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

RE: CCN: 245262
Cycle Start Date: June 2, 2022

Dear Administrator:

On June 2, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level isolated deficiencies that constituted immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On May 27, 2022, the situation of immediate jeopardy to potential health and safety cited at F689.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

This Department is recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 2, 2022 This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, West Wind Village is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 2, 2022 . This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically, or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245262	A. BUILDING _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND VILLAGE	1001 SCOTTS AVENUE MORRIS, MN 56267

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F 000	INITIAL COMMENTS On 5/31/22 through 6/2/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaint was SUBSTANTIATED at F689 for PAST NON-COMPLIANCE. H52621931C (MN00083854). The immediate jeopardy began on 5/26/22, when R1 tested positive for COVID-19 and was transferred from the locked memory care unit to a semi secure COVID-19 unit. R1 eloped from the building on 5/27/22 at 8:15 a.m. The administrator, and director of nursing (DON) were notified of the IJ on 6/2/22, at 9:15 a.m. and the facility implemented corrective action on 5/27/22, prior to the start of the survey and was issued at Past Noncompliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/15/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement appropriate interventions to protect 1 of 3 identified residents (R1) with wandering behaviors from leaving the facility unattended while in the COVID-19 isolation unit. As a result, R1 eloped from the facility on 5/27/22, which resulted in a potential risk of serious harm identified at immediate jeopardy. The immediate jeopardy (IJ) began on 5/26/22, when R1 was transferred from the secure locked memory care unit to the COVID-19 isolation unit. The administrator and director of nursing (DON) were notified of the IJ on 6/2/22 at 9:15 a.m. and the facility implemented corrective action on 5/27/22, prior to the start of the survey and was issued at Past Noncompliance.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2 Findings include: A Nursing Home Incident Report (NHIR) dated 5/27/22, indicted R1 had contracted COVID-19 and had been transferred from the facility's locked secure memory care unit (Rossberg Center) to a COVID-19 unit (Loher Lane) which was equipped with a 15 second delay egress exit to the outside. On 5/27/22, at 8:15 a.m. the exterior door alarm sounded, the direct care staff looked outside and did not see any residents. The staff members did a review of the residents residing in the COVID-19 unit and determined R1 was not present. Staff then began searching the facility grounds and found R1 outside with a neighbor. R1's Minimum Data Set (MDS) dated 5/10/22, identified R1 with severe cognitive impairment and diagnoses including Alzheimer's dementia, major depressive disorder and anxiety. R1's cognition Care Are Assessment (CAA) dated 5/10/22, indicated R1 was oriented to self but not to time or place. R1 was able to ambulate independently and required placement on the secure memory care unit. R1's care plan dated 7/6/20, identified R1 at risk for wandering and exit seeking behaviors. The plan directed the staff to ensure R1 was supervised when off of the secure unit. R1's Elopement Risk Assessment dated 1/1/22, indicated R1 hovered by outside doors, had a history of exit seeking behaviors, anxiety, delusions, searched for people not in the facility and was at risk to wander/elope from the facility.	F 689		

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F 689	Continued From page 3 R1's Assessment for Appropriate Placement on Alzheimer's/Dementia Unit dated 5/18/22, indicated R1 was independent with ambulation without assistive devices. R1 did not understand why she was at the facility and searched for ways to leave the facility. R1 had a history of becoming upset and would "bang on windows and doors." R1 was appropriate to remain on the secure locked unit. R1's Progress Notes (nurses notes) indicated the following information: -PN dated 5/26/22, at 2:03 p.m. R1 tested positive for SARS COVID-19 and was transferred to the COVID-19 isolation unit. R1 displayed no signs or symptoms of COVID-19. -PN dated 5/26/22, at 9:00 p.m. (entered on 6/1/22, at 3:38 a.m.) R1 refused dinner and any offered snacks. R1 has been pacing and very upset that she was unable to find her family. Staff spent time with R1 to attempt to cam her and provide reassurances. -PN dated 5/27/22, at 1:30 a.m. (entered on 6/1/22, at 3:36 a.m.) R1 had been upset about the temporary move to the COVID-19 unit. "She has been pacing, crying and wondering where her family is and if they know where she is." R1 was offered diversional activities such as having staff members ambulate with her, reading or watching videos. "Distractions work for about 15-20 minutes and then she gets back to pacing." -PN dated 5/27/22, at 5:45 a.m. (entered on 6/1/22, at 3:53 a.m.) R1 continued to pace and cry. R1 had periods of quiet time where she would sit with staff or by the window and look	F 689		

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F 689	Continued From page 4	F 689		

outside. R1 had not attempted to leave the facility.

-PN dated 5/27/22, at 8:15 a.m. (entered on 6/1/22, at 6:53 a.m.) the Loher Unit outside door sound and resident could not be located on the unit. Nursing assistant (NA)-A looked outside and did not see any residents. The DON "went outside and saw resident across the street talking to a neighbor and walking towards the facility." R1 was tearful and stated she "didn't know where to go." The DON then escorted R1 to the COVID-19 unit and an unidentified activity aide was directed to the COVID-19 unit to monitor R1.

-PN dated 5/28/22, at 5:00 a.m. (entered on 6/1/22 at 3:58 a.m.) R1 wandered thought the evening carrying her Bible and reading from it. R1 went to bed around 3:30 a.m.

-PN dated 5/29/22, at 9:30 p.m. (entered on 6/1/22 at 4:05 a.m.) R1 had a good evening with the activity staff. R1 walked throughout the unit with her Bible, reading occasionally. R1 did not attempt to leave the COVID-19 unit.

-PN dated 5/30/22 at 9:45 p.m. (entered on 6/1/22, at 4:42 a.m.) R1 was noted to pace on the COVID-19 unit.

-PN dated 5/31/22 at 9:15 p.m. (entered on 6/1/22, at 4:48 a.m.) R1 had no complaints or behaviors.

-PN dated 6/1/22, at 4:51 a.m. R1 remained asymptomatic for COVID-19. R1 was up during the night to use the restroom and returned to bed.

On 5/31/22, at 4:46 p.m. R1 was observed on the

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F 689	Continued From page 5	F 689		

Loher Lane COVID-19 unit. R1 ambulated independently to the State Agency (SA) staff member and stated she did not understand why she was at the facility, and she wanted to go home. R1 was observed to have a wander guard bracelet (a system which triggers an audible alarm when the person wearing the bracelet passes through a door egress equipped a sensor) on her wrist. R1 then turned and ambulated down the hallway. A large (approximately 6 foot by 8 foot) moveable see through red screen (welding screen) was observed to be placed at the end of the hallway at the egress between the resident room hallway and a small sitting room. The Loher Lane exterior exit door was located in the small sitting room.

On 5/31/22, at 5:00 p.m. NA-B stated the Loher Lane COVID-19 unit had been staffed with one NA and a nurse who worked on both COVID-19 units. NA-B stated the unit would occasionally have one staff member present for the 9 residents residing on the unit. However, after R1 left the facility on 5/27/22, the facility had assigned two nursing assistants to work on the Loher Lane unit to provide additional supervision for the residents with wandering behaviors.

On 5/31/22, at 5:08 p.m. NA-C stated the Loher Lane unit had increased staffing as of 5/27/22, due to R1 leaving the facility.

On 6/1/22, at 8:00 a.m. R1 was observed to be sleeping in a recliner in her room.

On 6/1/22, at 9:40 a.m. family member (FM)-A was interviewed via telephone. FM-A stated R1 had been on the secure unit since her admission

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F 689	Continued From page 6 to the facility in July 2020, due to wandering behaviors and confusion. FM-A stated R1 had not eloped from the facility in the past. In addition, R1 did not have concerns with elopement prior to placement in the facility or during home visits. The incident on 5/27/22, was R1's first elopement. On 6/1/22, at 9:50 a.m. the administrator stated the COVID-19 outbreak began on 5/16/22. This was the first facility COVID-19 outbreak involving the residents since the pandemic began in March 2020. When the residents from the memory care unit began to test positive, the facility focus was to move them into an isolation unit. The facility was in the process of starting a construction project and had two open wings Park Avenue unit and Loher Lane unit which were both transformed into COVID-19 isolation units. The Park Avenue unit was not equipped with any type of delayed egresses or wander guard system however, the Loher Lane unit was equipped with keypad operated doors to get onto the unit and a delayed egress exterior exit door. The administrator had discussed options of which COVID-19 unit to transfer residents from the memory care onto with the interdisciplinary team and corporate consultant. The Loher Lane unit was the better option due to established security. The administrator confirmed the facility did not complete a new comprehensive risk assessment for elopement for R1 upon transferring R1 from the secure memory care unit to the semi secure Loher Lane COVID-19 unit. After R1 exited the building new interventions had been implemented, however, a formal written documentation was not completed. On 6/1/22, at 12:09 p.m. R1 was observed	F 689		

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F 689	Continued From page 7 walking/pacing on the COVID-19 unit. R1 stated she wanted to go home. - At 12:11 p.m. R1 approached NA-D and informed her she did not like another resident. She stated the resident made her nervous and she wanted to go home. NA-D comforted R1 and offered her lunch. On 6/1/22, at 12:22 p.m. registered nurse (RN)-A stated she was on duty on 5/27/22, when R1 left the building. RN-A heard the alarm sound, initially didn't see any residents outside, but quickly identified R1 was not on the unit. RN-A directed the staff to look outside for R1, they found her and returned her to the unit. R1 was out of the building for approximately 10 minutes and did not sustain any type of injury while out of the building. Since that time, the facility put up the red screen at the end of the hallway, added a wander guard bracelet and they had increased the staff from one NA to two NA per shift on the Loher Lane COVID-19 unit. R1 had not left the unit since the staffing was increased. On 6/1/22, at 12:26 p.m. maintenance staff (MS)-A was observed to be working on installing a new mechanical device to the Loher Lane interior entrance door. MS-A stated the device was to increase the security of the Loher Lane unit by increasing the delayed response for the door to open. MS-A stated the exit door delayed response had been increased on 5/27/22, and the new mechanical parts would further increase the delay time. The parts had been ordered on 5/27/22 and arrived at the facility on 6/1/22. On 6/1/22, at 2:18 p.m. the director of environmental services (DES) stated a delayed egress door was a door which was equipped with	F 689		

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F 689	Continued From page 8 a magnetic locking system. Initially when the door knob was turned, the door would not open, however, if the door knob is turned and held for 15 seconds, the door would open. DES stated R1 held the door for 15 seconds on 5/27/22 and was able to elope. Since that time, he had added a wander guard system to the doorway, had placed wander guard alert bracelets on three residents (R1, R2 and R4) who had been in the secure memory care unit and displayed wandering behaviors. In addition, the delayed egress response of the exterior door on Loher Lane had been attempted to be increased from 15 seconds to 30 seconds. However, an alarm technician was required to make the change. The alarm technician was called on 5/27/22 and was scheduled to arrive on 6/2/22. In the meantime, DSE had added the welding screen to the unit to add additional diversion from the exterior door and an updated magnetic locking system was added to interior door. On 6/1/22, at 2:30 p.m. the director of nurses (DON) stated the COVID-19 outbreak began on 5/16/22. Since that time 23 residents had been identified as positive with COVID-19. Six of the residents were from the memory care unit and three of them (including R1) displayed wandering behaviors. The DON stated the moment the residents were identified with COVID-19, the facility priority was to transfer the residents into an isolation unit. The DON confirmed the residents from the memory care unit required the security due to wandering behaviors, however, the facility focus was on mitigating the spread of COVID-19. Since R1's elopement, the facility had increased staffing on the Loher Lane COVID unit, added wander guards to the residents at risk of wandering, installed the welding screen and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245262	A. BUILDING _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND VILLAGE	1001 SCOTTS AVENUE MORRIS, MN 56267

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F 689	Continued From page 9 improved the locking mechanisms on the doors. The DON confirmed all staff had been notified of the changes during shift report. On 6/1/22, at 3:00 p.m. the DON escorted the State Agency staff to the area in which R1 eloped. The exit door of the Loher Lane had a small sidewalk surrounded by a large grassy lawn. The lawn was adjacent to the employee parking lot, a residential street and the neighbor's home. The DON confirmed the distance between the Loher Lane door and the neighbor's home was approximately 300-350 feet. The COVID-19 Segregation and Isolation Measures policy dated 9/17/21, directed the staff to relocate the resident to a segregated area to impose a strict isolation to prevent the spread of the disease. The Elopement Policy dated 3/7/22, directed the staff to 1) evaluate any resident who had eloped for potential injury, 2) notify family and physician, 3) conduct an investigation to determine how the elopement occurred in order to correct any underling contributing factor, 4) complete and incident report and 5) report the elopement to the state agency. The immediate jeopardy that was removed on 6/2/22, at 9:15 a.m. after it was verified the facility completed the following actions before the abbreviated survey: -R1's elopement was reported timely in accordance with facility reporting procedures and the regulation. -The facility immediately reassessed R1 and put appropriate interventions in place that included: - Increased supervision on the Loher Lane	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 10 COVID-19 unit. - Wander guard bracelets were applied R1 and all at risk residents who had a history of wandering behaviors. - A welding screen was placed at the end of the Loher Lance hallway to deter residents from the exit door without blocking the exit door. - The facility provided education to the facility staff to ensure two staff members were present on the Loher Lane unit.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 14, 2022

Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

Re: Event ID: IESX11

Dear Administrator:

The above facility survey was completed on June 2, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00654	A. BUILDING: _____ B. WING _____	C 06/02/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/31/22- 6/2/22 , a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure.	2 000		

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	00654	A. BUILDING: _____ B. WING _____	C 06/02/2022

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED:H52621931C (MN00083854) with a no licensing order issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		